Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WAYNE SOIGNIER MD
10109 MCKALLA PLACE SUITE E
AUSTIN TX 78758

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1804-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "per Medical Fee Guideline."

Amount in Dispute: $55.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill(s) made the basis of this Medical Fee Dispute have been sent back the bill audit vendor for an additional review along with the information provided by the Requestor."

Response Submitted by: Pappas & Suchma, PC, P. O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2011	99456-W8-RE	$55.00	$55.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 18, 2011
   - 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.

   Explanation of benefits dated January 11, 2012
   - 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 16 – (16) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THE PREVIOUSLY REVIEWED BILL.

Issues

1. Will the Division address the new issue raised by the respondent in their response to this dispute
2. Were the services in dispute appropriately billed?
3. Has the Return to Work examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Review of the insurance carrier's response summary dated February 13, 2011 states, "The medical bill(s) made the basis of this Medical Fee Dispute have been sent back the bill audit vendor for an additional review along with the information provided by the Requestor." Review of the insurance carrier's supplemental response summary dated February 22, 2011 states, "The medical bill(s) made the basis of this Medical Fee Dispute was sent back to the bill audit vendor for an additional review along with the information provided by the Requestor. The fee schedule team has determined the system is applying the correct allowance to the bill. The system is applying the multiple procedure correctly, as indicated on page 27 of the link provided below. Under the "Tiered reimbursement method for more than one non-MMI/IR examinations under the same order' section"…"Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR) as outlined in §134.204(i) 1st = 100% of fee 2nd = 50% of fee subsequent = 25% of fee" The billing in question…, is applying the multiple reduction correctly to CPT 99456 w/W8.RE at 25% because it is the third Non-MMI/IR Examination for the life of this WC claim #002746-003076-WC-01." The respondent asserts in their response that the billing in question… is applying the multiple reduction correctly to CPT 99456 w/W8.RE at 25% because it is the third Non-MMI/IR Examination for the life of this WC claim, however did not provide documentation to support this assertion. Per 28 Texas Administrative Code §133.307(d)(2)(B), "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Per 28 Texas Administrative Code §133.307(d)(2)(B), this new issue will not be further addressed in this dispute review.
2. The requestor billed the amount of $500.00 for CPT code 99456-W8-RE with 1 (one) unit in Box 24G of the CMS-1500 for a Return to Work (RTW) examination.

   28 Texas Administrative Code §134.204(k) states in pertinent part, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE'. In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports.

3. Per 28 Texas Administrative Code §134.204(i)(2)(A) and (k), the MAR for the Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00.
4. The respondent has previously reimbursed $125.00 on CPT code 99456-W8-RE. The requestor's submitted *Table of Disputed Services* shows $55.00 as the amount in dispute, therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $55.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $55.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 10, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.